MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13817 **CERTIFICATE OF DEATH** 13792

1. **PLACE OF DEATH**
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Rural
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rock Run

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Rural
d. STREET ADDRESS: Rock Run
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Andrew — Middle: Robert — Last: Bannon

4. **DATE OF DEATH**: Month: Dec. — Day: 12, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 21, 1903

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rigger

10b. KIND OF BUSINESS OR INDUSTRY: Army Chemical Center.

11. BIRTHPLACE (County & State, or foreign country): Cecil Co., Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Andrew J. Bannon

14. MOTHER'S MAIDEN NAME: Dollie E. Wills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-09-3797

17. INFORMANT: Mabel O. Bannon, Address: Port Deposit, Md. Rural

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis — 3 yrs

DUE TO (c): Chr. Myocarditis — 8 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June — 1954 to Dec-12, 1961, that (I) (we) last saw the deceased alive on Dec-12 1961, and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: Clarence I Benson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Dec-13-61

22c. PHYSICIAN'S NAME (Type): Clarence I. Benson M.D.

22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-15-1961

23c. NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.

23d. LOCATION (City, town or county) (State): Colora, Md. Rural

24. FUNERAL DIRECTOR'S SIGNATURE: Lee A. Patterson & Son — ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE: DEC 18 '61

25b. REGISTRAR'S SIGNATURE

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) ISM 9/60

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FOR STATE HEALTH DEPT.

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2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13813 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 18793

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent; prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN Ib: 6 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elkton, R.D.3.
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: Gail — Last: Bonham

4. DATE OF DEATH: Month: 12 — Day: 23 — Year: 19 61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11-22-1955

9. AGE (In years last birthday): 6 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James R. Bonham

14. MOTHER'S MAIDEN NAME: Fanny L. Strope

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: ———

17. INFORMANT — Address: James R. Bonham, Elkton R.D.3. Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture of both Femurs and fracture at base of skull — INTERVAL BETWEEN ONSET AND DEATH: 5. min.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

V812X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Was hit by car as she ran across the road

20c. TIME OF INJURY Hour: 2.45 p.m. — Month, Day, Year: 12 23 61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Road

20f. (City or town): Elkton — (County): Cecil — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type): R.C. Dodson

(Address — Street and number, or town, or county): Rising Sun, Md.

12-21-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-27-61

22c. NAME OF CEMETERY OR CREMATORY: N. E. Methodist Cem.

22d. LOCATION (City, town, or country): North East, — (State): Md.

23. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME

ADDRESS: Donald St. Elkton, Md.

24a. REC'D BY REGISTRAR DATE: DEC 27 '61

24b. REGISTRAR'S SIGNATURE: Clifton L. Kraus

Fracture of both femurs and fracture at base of skull 5. min.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13819 — 13794

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
   c. LENGTH OF STAY IN 1b: 3 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen 1228 2
   d. STREET ADDRESS: 6 Taft
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALBERT — Middle: (NMI) — Last: BRAUN

4. DATE OF DEATH: Month: December — Day: 20 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-24-80

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Not available

14. MOTHER'S MAIDEN NAME: Not available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes — S.A.W.

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): Pneumonia — 420.0
- DUE TO (b): Arteriosclerotic Heart Disease
- DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: a.m. / p.m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-17, 1961, to 12-20, 1961 [illegible] and that death occured at 8:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: S. Goldgraben — M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12-21-61

22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN

22d. ADDRESS: Chief, Medical Service VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE THEREOF: 12/22/1961

23c. NAME OF CEMETERY OR CREMATORY: Baltimore

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR — DATE: DEC 26 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Furnow

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13820

CERTIFICATE OF DEATH

13796

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE 03x-2
d. STREET ADDRESS: 2254 Graythorn Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD — Middle OLIVER — Last BULETTE

4. DATE OF DEATH: Month December — Day 23 — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: February 23, 1932

9. AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mail Carrier

10b. KIND OF BUSINESS OR INDUSTRY: Postal Service

11. BIRTHPLACE (County & State, or foreign country): Harford County, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hugh Bulette

14. MOTHER'S MAIDEN NAME: Florence Burkentine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): Korean

16. SOCIAL SECURITY NO.: 213-26-1124

17. INFORMANT — Address: Hospital Records, VA Hospital, Perry Point, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia, severe — INTERVAL BETWEEN ONSET AND DEATH: 4-6 weeks
DUE TO (b): Chronic Glomulonephritis — Years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

572 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a.m. p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from December 7, 1961 to December 23, 1961 that I (we) last saw the deceased alive on Dec. 23rd, 19 61 and that death occured at 7:15 PM from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-23-61

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D. Asst. Clinical
22d. ADDRESS: Pathologist, VAH., Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: DEC. 27 1961
23c. NAME OF CEMETERY OR CREMATORY: Mt. Erin
23d. LOCATION (City, town or county) (State): Havre DeGrace Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R. Madison Mitchell
R. MADISON MITCHELL, Havre DeGrace, Md.

25a. REC'D BY REGISTRAR DATE: DEC 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13821 — Reg. Dist. No. 8797

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RISING SUN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RISING SUN
d. STREET ADDRESS: PEARL STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLE Middle FREDRICK Last BURKINS, SR
4. DATE OF DEATH: Month DECEMBER Day 5 Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 4, 1903
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ACETYLENE BORNER
10b. KIND OF BUSINESS OR INDUSTRY: STEEL WORKS
11. BIRTHPLACE (State or foreign country): PENN.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM ALFRED BURKINS
14. MOTHER'S MAIDEN NAME: LAURA M. SHADE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-01-8683
17. INFORMANT — Address: MRS HAZEL BURKINS, RISING SUN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary insufficiency — 10 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/15, 1954 to 12/5, 1961, that I last saw the deceased alive on 12/5, 1961, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md — DATE SIGNED: 12/7/61

PHYSICIAN'S NAME (Type): Neil Taylor Jr MD Rising Sun, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/8/1961
22c. NAME OF CEMETERY OR CREMATORY: WEST NOTTINGHAM
22d. LOCATION (City, town, or county) (State): COLORA MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ralph M. Reed, Rising Sun, Md
24a. REC'D BY REGISTRAR DATE: DEC 8 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Knaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13822

CERTIFICATE OF DEATH

Reg. Dist. No. 13798

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Devine Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elkton
d. STREET ADDRESS: Rd # 4,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Harry — Last: Carter

4. DATE OF DEATH: Month: 12 — Day: 25 — Year: 19 61

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 29 1880

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cabinet maker *

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11 BIRTHPLACE (State or foreign country): Marylnd

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jonathan V. Carter

14. MOTHER'S MAIDEN NAME: Mary R. Chaster

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-30-1225

INFORMANT: Elva Bostic Address: RD3 Coatsville, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
420 1
DUE TO (b): Coronary artery heart disease — several yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 15, 19 61 to Dec. 25, 19 61, that I last saw the deceased alive on Dec. 24, 19 61, and that death occurred at 10:15a M, from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: S. Ralph Andrews, Jr. M.D. — ADDRESS (Street, city or town, state): 233 E. Main St., Elkton, Md. — DATE SIGNED: 12/25/61

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. Elkton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/27/61

22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Cemetery

22d. LOCATION (City, town, or county): Cherry Hill (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Walter de Boy Jr. — ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: JAN 2 '62

24b REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13823

CERTIFICATE OF DEATH

13799

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 5mo.19days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 631 Maryland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GLENN — Middle HOWARD — Last CORNELL

4. DATE OF DEATH: Month December — Day 3 — Year 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-16-89
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Not available
10b. KIND OF BUSINESS OR INDUSTRY: Not available
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ralph Cornell
14. MOTHER'S MAIDEN NAME: Ellie Spevil

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW-I
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital Records VAH, Perry Point, Md.
Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia left lung, severe — INTERVAL BETWEEN ONSET AND DEATH: 10-14 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease — unknown
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis generalized, - unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: VA 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from June 14, 1961 to December 3, 1961 and that death occured at 3:15 pm from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-4-61
22c. PHYSICIAN'S NAME (Type): A. L. MOONEY Asst. Clinical
22d. ADDRESS: Pathologist, VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 12/7/61
23c. NAME OF CEMETERY OR CREMATORY: Unknown
23d. LOCATION (City, town or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son, Havre de Grace, Md.
ADDRESS:
25a. REC'D BY REGISTRAR DATE: DEC 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13824 **CERTIFICATE OF DEATH** 13800

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
   c. LENGTH OF STAY IN 1b: 10 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 3515 Meadowside Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: ELLSWORTH — Middle: G. — Last: CROPSEY

4. **DATE OF DEATH**: Month: December — Day: 19 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-28-98

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Cropsey (deceased)

14. MOTHER'S MAIDEN NAME: Lucy Hackley (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: Not available

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Ventricular Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: 5-10 min.

DUE TO (b): Arteriosclerotic heart disease — Years

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ~~(I did not attend)~~ attended the deceased from December 9 19 61 to December 19 61 ~~that (I) (we) last saw the deceased alive on~~ and that death occured 9:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12-20-61

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL — 23b. DATE THEREOF: 12/21/1961

23c. NAME OF CEMETERY OR CREMATORY: National Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR: DATE DEC 26 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13825

CERTIFICATE OF DEATH

Reg. Dist. No. 13801

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

c. LENGTH OF STAY IN 1b: 4½ yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 101 Washington Avenue

d. STREET ADDRESS: 101 Washington Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laura Middle: Virginia Last: DAVIS

4. DATE OF DEATH: Month: Dec. Day: 28 Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 12, 1885

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Nr. Elkton, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard Beers

14. MOTHER'S MAIDEN NAME: Sara E. Curry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-05-3877

17. INFORMANT: Address: Margaret Bryson, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): CVA — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO (b): Arteriosclerotic cardio-vascular disease — 10 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 11, 19 59 to Dec. 28, 19 61 that I last saw the deceased alive on Dec. 26, 1961, and that death occurred at 3:45 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel J. Wright M.D. — Dec. 28, 1961

ADDRESS (Street, city or town, state): 79 Amstel Avenue Newark, Del. — DATE SIGNED

PHYSICIAN'S NAME (Type): Samuel J. Wright, M.D. — Dec. 29, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-30-61

22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Meth. Cem.

22d. LOCATION (City, town, or county) (State): Cherry Hill, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME — ADDRESS: Donald M. Pippin Elkton, Md.

24a. REC'D BY REGISTRAR: DATE JAN 2 '62

24b. REGISTRAR'S SIGNATURE: Evelyn L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13826 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13802

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 30 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elkton
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anthony Middle: R Last: Dvorak Jr.

4. DATE OF DEATH: Month: 12 Day: 15 Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11-17-60

9. AGE (In years last birthday): 1 yrs. IF UNDER 1 YEAR: Months: Days: 28 IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Anthony Dvorak

14. MOTHER'S MAIDEN NAME: Ruth Di Feresi nan de

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Anthony Dvorak Address: Mt. Elton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
560.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Operation left Inguinal hernia
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒ XX Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: R.C. Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12-15-61

EXAMINER'S NAME (Type): R.C. Dodson

Address (Street, city, town, or county): Rising Sun

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/18/61

22c. NAME OF CEMETERY OR CREMATORY: Immaculate Conception

22d. LOCATION (City, town, or country) (State): Nr. Elkton, Maryland

23. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME ADDRESS: Rod & Dee Elkton, Md

24a. REC'D BY REGISTRAR DATE: DEC 20 '61

24b. REGISTRAR'S SIGNATURE: Clara L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13827 13803

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 28 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 110 Bridge Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALFRED — Middle LEROY — Last EDER

4. DATE OF DEATH: Month December — Day 24, — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 2/6/92

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Custodian

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fred W. Eder (Deceased)

14. MOTHER'S MAIDEN NAME: Mary Harrington (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 219-03-3611

17. INFORMANT — Address: VA Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 7-10 Days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CARCINOMA OF TONGUE WITH METASTASIS TO LIVER — 7 Months
DUE TO
(c)

141.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I,a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 11/26/ , 19 61 to 12/24/ , 19 61, that ☒ [redacted] and that death occured at 5:40 PM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12/24/61

22c. PHYSICIAN'S NAME (Type): A. L. Mooney, M.D.

22d. ADDRESS: VAH, Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-28-61

23c. NAME OF CEMETERY OR CREMATORY: Immaculate Conception Cem.

23d. LOCATION (City, town or county) (State): Elkton, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pippins Funeral Home, Elkton, Md. [signature]

25a. REC'D BY REGISTRAR DATE: DEC 27 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Evans

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13828 — 13804

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: Rt. 2, Box 24
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ADOLPH — Middle: S. — Last: ELASEWITCH

4. DATE OF DEATH: Month: December — Day: 7 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8-5-96

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard (retired)

10b. KIND OF BUSINESS OR INDUSTRY: Army Chemical Center

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Adam Elasewitch (deceased)

14. MOTHER'S MAIDEN NAME: Margaret Seibert (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes — WW-I

16. SOCIAL SECURITY NO.: 220-03-0299

17. INFORMANT: Not available — Address: Hospital Records, VAH, Perry Point, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Ventricular arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: 1-3 minutes

420.0

DUE TO (b): Arteriosclerotic heart disease severe with myocardial fibrosis and mural thrombosis — unknown

DUE TO (c): Arteriosclerosis generalized

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that I attended the deceased from November 29 1961, to December 7, 1961 and that death occured at 8:30 a.m. from the causes and on the date stated above

22a. SIGNATURE: A. L. Mooney, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 12-7-61

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 23b. DATE THEREOF: Dec.8,1961

23c. NAME OF CEMETERY OR CREMATORY: Lindsey & Sons, F.H., — ADDRESS: Abingdon, Md.,

23d. LOCATION (City, town or county) (State): Harrisonburg Va.,

24. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McComas & Son — Howard K. McComas Jr.

25a. REC'D BY REGISTRAR — DATE: DEC 11 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13829 **CERTIFICATE OF DEATH** 13805

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN: MARYLAND 18 MONTHS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Devine Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown 142 1
d. STREET ADDRESS: Queen St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry Middle Last Fowler
4. DATE OF DEATH: Month 12/2/61 Day Year 19
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ W DOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/16/1874
9. AGE (In years last birthday): 87 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer at Lumber yard
10b. KIND OF BUSINESS OR INDUSTRY: Kent Co.
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Fowler
14. MOTHER'S MAIDEN NAME: Emma ~~Ford~~ DeFord
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 213-05-5017
17. INFORMANT Address: Clarence Fowler - Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
DUE TO (b): Cerebral Arteriosclerosis — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
332 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 1, 19 61 to Dec 2, 19 61, that (I) (we) last saw the deceased alive on Dec 2 19 61, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain
22b. DATE SIGNED: 2 Dec 61
22c. PHYSICIAN'S NAME (Type): Wallace Obenshain
M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: Cecilton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: L2/5/61
23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
23d. LOCATION (City, town or county) [State]: Chestertown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: DEC 5 '61
25b. REGISTRAR'S SIGNATURE: Curtis L. Evans

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13830 — 13806

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: MARYLAND 30 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Front St.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Perryville
d. STREET ADDRESS: Front St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Claude; Middle S.; Last Hackler

4. DATE OF DEATH: Month Dec.; Day 15; Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 9, 1909

9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Transportation Dispatcher.

10b. KIND OF BUSINESS OR INDUSTRY: U S V Hospital.

11. BIRTHPLACE (County & State, or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Bruce Hackler

14. MOTHER'S MAIDEN NAME: Cynthia Hash

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes World W. 2

16. SOCIAL SECURITY NO: 721-18-0031.

17. INFORMANT: Ruth Stowell

Address: North East, Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage (Intracranial) — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

DUE TO (b): Cerebral Embolism — 5 minutes

DUE TO (c): Coronary Thrombosis (Hypertension) — Hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from June, 1945 to December 14 1961, that (I) (we) last saw the deceased alive on December 14 1961, and that death occured at 3A M, from the causes and on the date stated above.

22a. SIGNATURE: Frank Wolbert MD

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: December 14 1961

22c. PHYSICIAN'S NAME (Type): FRANK WOLBERT MD

22d. ADDRESS: HAVRE DE GRACE MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 18, 1961

23c. NAME OF CEMETERY OR CREMATORY: Hopewell Cemetery

23d. LOCATION (City, town or county) (State): Port Deposit, Md. Rural

24. FUNERAL DIRECTOR'S SIGNATURE: Vera, Patterson & Son,

ADDRESS: Perryville, Md

25a. REC'D BY REGISTRAR DATE: DEC 18 '61

25b. REGISTRAR'S SIGNATURE: C. Allen L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13831

CERTIFICATE OF DEATH

Reg. Dist. No. 13807

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 Day
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chesapeake City

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Viola Middle H Last Harrington
4. DATE OF DEATH: Month Dec. Day 20 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 4, 1882
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Rising Sun, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert C. Harrington
14. MOTHER'S MAIDEN NAME: Sarah Hoopes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT Address: Mrs. William Lupfer, Chesapeake City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
592 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Nephritis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 10, 1961, to Dec 20, 1961, that I last saw the deceased alive on Dec 20, 1961, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry U. Davis M.D.
ADDRESS (Street, city or town, state): Chesapeake City Md
DATE SIGNED: 12/20/61

PHYSICIAN'S NAME (Type): HENRY U. DAVIS M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-23-61
22c. NAME OF CEMETERY OR CREMATORY: West Nottingham
22d. LOCATION (City, town, or county) (State): Rising Sun R.D. Cecil, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant
ADDRESS: North East, Md.
24a. REC'D BY REGISTRAR DATE: DEC 27 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13832

CERTIFICATE OF DEATH

13808

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point, Md.
c. LENGTH OF STAY IN 1b: 57 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pa. — b. COUNTY: York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fawn Grove
d. STREET ADDRESS: General Delivery
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Avon — Middle: W. — Last: Hess
4. DATE OF DEATH: Month: 12 — Day: 21 — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-4-93
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months 11 — Days 17 — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (County & State, or foreign country): Stewartstown, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Abraham Lincoln Hess
14. MOTHER'S MAIDEN NAME: ANNIE Shue (First name not available)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 159-03-5812
17. INFORMANT — Address: VA Hospital Records - VA Hospital Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: VA 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that ~~I am the physician~~ attended the deceased from Oct. 25, 1961 to Dec. 21, 1961, ~~and last saw the deceased on~~ 19...., and that death occured 6:45 a.m., from the causes and on the date stated above.

22a. SIGNATURE: S. Goldgraben M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-21-61
22c. PHYSICIAN'S NAME (Type): S. GOLDGraben, Chief, Medical Service
22d. ADDRESS: VA Hospital - Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12 23 61
23c. NAME OF CEMETERY OR CREMATORY: First Methodist Church Cemetery - Fawn Grove, Pa.
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE: K. W. Osburn
ADDRESS: OSBURN FUNERAL HOME - Stewartstown, Pa.

25a. REC'D BY REGISTRAR DATE: DEC 26 '61
25b. REGISTRAR'S SIGNATURE: Curtis L. Evans

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13833

CERTIFICATE OF DEATH

Item 8 Film 6303 12/27/61 mh

13809

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Cecil
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: MARYLAND Lifetime
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elk Mills,
   d. STREET ADDRESS: Rd # 4,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Frances Middle: A. Last: Jackson

4. **DATE OF DEATH**: Month: 12 Day: 13 Year: 1961

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/24/1961 1888

9. AGE (In years last birthday): 73 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: House Work

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Aument

14. MOTHER'S MAIDEN NAME: Ella Forbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Walter Jackson Address: Elk Mills, Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Carcinoma of the colon — INTERVAL BETWEEN ONSET AND DEATH: unknown over 4 months

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 153.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 29 61 6:06p to Dec. 13 61, that (I) (we) last saw the deceased alive on Dec. 13 61, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: S. Ralph Andrews, Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/13/61

22c. PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D.

22d. ADDRESS: 233 E. Main St., Elkton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/16;61

23c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Cemetery

23d. LOCATION (City, town or county) (State): Cherry Hill Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Walter Jackson Jr. ADDRESS: Elkton, Md.

25a. REC'D BY REGISTRAR DATE: DEC 18 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Evans

VR A15 (4) 15M 7.61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13834

CERTIFICATE OF DEATH

13810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 ... be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely ... d in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
c. LENGTH OF STAY IN 1b: 6 Mo.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peral Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rising Sun
d STREET ADDRESS: Peral Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Marie — Last: Kennard

4. DATE OF DEATH: Month: 12/ — Day: 20 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 18, 1880

9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Allison Henry

14. MOTHER'S MAIDEN NAME: Mary Burkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Joseph Pogue — Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 Wks
DUE TO (b): Generalized Arteriosclerosis — 3 Yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4500

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 6 9 1960, to 12/20 1961, that (I) (we) last saw the deceased alive on 12/19 1961, and that death occurred on ___, M, from the causes and on the date stated above.

22a SIGNATURE: Neil R Taylor, M D

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Neil R. Taylor Jr.

22d. ADDRESS: Rising Sun, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 12/23/1961

23c NAME OF CEMETERY OR CREMATORY: West Nottingham Cem

23d LOCATION (City, town, or county) (State): Colora Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Herman E. McMullen — ADDRESS: Rising Sun, Md.

25a REC'D BY REGISTRAR DATE: DEC 27 '61

25b. REGISTRAR'S SIGNATURE: William S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13835

CERTIFICATE OF DEATH

Reg. Dist. No. 13811

1. PLACE OF DEATH
a. COUNTY Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton
c. LENGTH OF STAY IN 1b: 36 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. — b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City
d. STREET ADDRESS: 1 BOHEMIA AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mary — Middle ELIZABETH — Last Lee

4. DATE OF DEATH: Month Dec — Day 10 — Year 19 61

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JUNE 17, 18 93
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): Elkton Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Hughes
14. MOTHER'S MAIDEN NAME: Anna Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: FRANK LEE — Address: CHESAPEAKE CITY, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebellar Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 36 hours.
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis — years.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Nephrosclerosis, Coronary Arteriosclerosis, Huge ovarian Cyst.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 19 61, to 10 Dec, 19 61, that I last saw the deceased alive on 10 Dec, 19 61, and that death occurred at 11 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 11 Dec 61

PHYSICIAN'S NAME (Type): Wallace Obenshain — Cecilton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: DEC. 14, 1961
22c. NAME OF CEMETERY OR CREMATORY: ELKTON CEMETERY
22d. LOCATION (City, town, or county) (State): ELKTON, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: P. PENN FUNERAL HOME Donald R. Penn
ADDRESS: ELKTON, Md
24a. REC'D BY REGISTRAR DATE: DEC 14 '61
24b. REGISTRAR'S SIGNATURE: Caroline S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13836 13812

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
   c. LENGTH OF STAY IN 1b: 8yrs.9mo.8days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Pennsylvania — b. COUNTY: ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia
   d. STREET ADDRESS: 4247 Penn Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: WILLIAM — Middle: J. — Last: LEIPERT

4. **DATE OF DEATH**: Month: December — Day: 14 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3-5-88

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Leipert

14. MOTHER'S MAIDEN NAME: Not available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: 168-16-6890

17. INFORMANT: Hospital Records, VAH, Perry Point, Md. — Address

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pericarditis	15-20 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (b)	Uremia	15-20 days
(c)	Arterionephrosclerosis	unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (did not) attended the deceased from March 6 ..... 1953, to December 14 ..... 61 that I (do) last saw deceased alive on ..... 19 ..... and that death occured at 4:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12-14-61

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY

22d. ADDRESS: Asst. Clinical Pathologist, VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 12/18/61

23c. NAME OF CEMETERY OR CREMATORY: Beverly National

23d. LOCATION (City, town or county) (State): Beverly, New Jersey

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son

ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: DEC 26 '61

25b. REGISTRAR'S SIGNATURE: Carlton S. Evans

VR A1S (4) 15M 7 61

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13837 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13813

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Cecil
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City
   c. LENGTH OF STAY IN 1b: MARYLAND 20 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chesapeake City
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Charles	WESTON	Loveless	Dec.	20,	1961

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	WIDOWED ☒	May 24, 1883	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Boats	General Laborer	NEW JERSEY	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Loveless	Rachel Horner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	339-16-0574	Rachel Loveless, Chesapeake City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cronia Myocarditis Hypertersion — INTERVAL BETWEEN ONSET AND DEATH: 3 Hrs.

413X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. / Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) R. C. DODSON, M.D. M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Rising Sun, Md.

DATE SIGNED: 12-20-61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
BURIAL	12/23/61	BETHEL CEMETERY	NR. CHESAPEAKE CITY, Md.

23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
PIPER FUNERAL HOME	Grad Ave Elkton, Md.	DATE DEC 22 '61	[signature]

VS. A15ME
5M 7/59

1

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. AISME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13838

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: MARYLAND all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS: Providence, Elkton, R.D.5.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pierce Middle: Taylor Last: Malon (MALIN)

4. DATE OF DEATH: Month: 12 Day: 19 Year: 19 61

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-23-1913

9. AGE (In years last birthday): 48 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Junk Dealer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bennett Lelon Malon

14. MOTHER'S MAIDEN NAME: Elizabeth Catherin Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes WW II

16. SOCIAL SECURITY NO.: 222-07-0963

17. INFORMANT: Mrs. Peirf Taylor Malin, Elkton, R.D.5. Md.
Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carbon Monoxide Poisoning
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
Attached hose of tail pipe and inside of cab of truck

20c. TIME OF INJURY: Hour a.m. 12-50 p.m. Month, Day, Year: 12 19 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Junk Yard

20f. (City or town) (County) (State): Elkton R.D.5 Cecil Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12-20-61

EXAMINER'S NAME (Type): R.C. Dodson

Address (City, town, or county): Rising Sun. Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/23/61

22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Cem.

22d. LOCATION (City, town, or country) (State): Cecil County, Md.

23. FUNERAL DIRECTOR ADDRESS: Ralph E. Hicks, Elkton, Md

24a. REC'D BY REGISTRAR DATE: JAN 11 '62

24b. REG.STRAR'S SIGNATURE: Catherine L. Nimm

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13839 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13814

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Elkton
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Browns Shore

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Elkton
d. STREET ADDRESS: Browns Shore
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maurice; Middle: Henry; Last: Matsinger, Jr.

4. DATE OF DEATH: Month: Dec. Day: 19 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 17, 1914

9. AGE (In years last birthday): 47 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Maintence

11. BIRTHPLACE (State or foreign country): Philadelphia, Penna.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Morris H. Matsinger, Sr.

14. MOTHER'S MAIDEN NAME: Irene Kennedy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 173-10-1560

17. INFORMANT: Lucille Matsinger, Address: R. D. #1, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 22 Bullet in the forehead — INTERVAL BETWEEN ONSET AND DEATH: 5 Min.
976X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Shot self with 22 caliber rifle.

20c. TIME OF INJURY: Hour: 3:05 a.m. / p.m. Month, Day, Year: 12/19/61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Residence

20f. (City or town): R.D. #1, Elkton, (County): Cecil, (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R C Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): R. C. DODSON, M.D. Address (Street, town or city): Rising Sun, Md.

DATE SIGNED: 12-20-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-22-61

22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Mem. Pk.

22d. LOCATION (City, town, or country): Nr. Elkton, (State): Md.

23. FUNERAL DIRECTOR: HIPPIN FUNERAL HOME ADDRESS: Donald M. Dee Elkton, Md.

24a. REC'D BY REGISTRAR: DEC 22 '61

24b. REGISTRAR'S SIGNATURE: A. S. Nims

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13840

CERTIFICATE OF DEATH

13815

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
   c. LENGTH OF STAY IN 1b: 6 mo.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: Virginia — b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Springfield
   d. STREET ADDRESS: 5303 Clifton Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: JOSEPH — Middle: (N)one — Last: MOFFATT

4. **DATE OF DEATH**: Month: 12 — Day: 18 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-26-93

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steamfitter

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): New Castle, Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH MOFFATT

14. MOTHER'S MAIDEN NAME: SARAH NIMMO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes — WW-1

16. SOCIAL SECURITY NO.: 577-24-6257

17. INFORMANT: Mrs. Ada E. Moffatt (Wife) — Address: 5303 Clifton St., Springfield, Va.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Lobar Pneumonia, left lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 7 To 10 Dys.

DUE TO (b): Old Myocardial Infarction — Approx. 6 Mon.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. **I certify** that I (this hospital) attended the deceased from 6-15- ..... , 1961 , to 12-18 ..... , 19 61 , last saw the deceased alive on ..... 19 ... , and that death occured at 2:PM, from the causes and on the date stated above.

22a. SIGNATURE: G. L. Mooney — M D — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12-18-61

22c. PHYSICIAN'S NAME (Type): A.L. MOONEY, M.D.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) — 23b. DATE THEREOF: 12/20/61 — 23c. NAME OF CEMETERY OR CREMATORY: Arlington National — 23d. LOCATION (City, town or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR — DATE: DEC 26 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

VR A15 (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13841 13816

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit, Rural
c. LENGTH OF STAY IN 1b: 3 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City, Rural
d. STREET ADDRESS:
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel; Middle: D.; Last: Moore

4. DATE OF DEATH: Month: Dec.; Day: 18; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 5, 1885

9. AGE (In years last b.rthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: U S Government

11. BIRTHPLACE (County & State, or foreign country): Cecil Co., Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Moore

14. MOTHER'S MAIDEN NAME: Sarah Ann Parks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 169-20-1560

17. INFORMANT: Mrs Cyrus Burlin, Port Deposit, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRO-VASCULAR Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO (b): HYPERTENSIVE CARDIO VASCULAR — 10 yrs
DUE TO (c): DISEASE & SCLEROSIS — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): INFLUENZA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. / Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1961, to Dec 18, 1961, that (I) (we) last saw the deceased alive on 12-18-61, 1961, and that death occured at 8:45 M, from the causes and on the date stated above.

22a. SIGNATURE: G. H. Richards, Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-19-61

22c. PHYSICIAN'S NAME (Type): G.H.Richards Jr.

22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-21-1961

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION (City, town or county) (State): Port Deposit, Md. Rural

24. FUNERAL DIRECTOR'S SIGNATURE: Vera Patterson & Son

ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE: DEC 22 61

25b. REGISTRAR'S SIGNATURE

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

B 1 M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13842 **CERTIFICATE OF DEATH** 13817

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 109 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VAH, Perry Point, Maryland

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: P. G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
d. STREET ADDRESS: Post Office Box 245
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: HENRY — Middle: C. — Last: PEITZ

4. DATE OF DEATH — Month: December — Day: 19, — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/12/90
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Navy
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Peitz
14. MOTHER'S MAIDEN NAME: Katie Hess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WWI & II
16. SOCIAL SECURITY NO: Unk.
17. INFORMANT — Address: VA Records, VAH, Perry Point, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL — 7-10 Days

350.0

DUE TO (b) DEBILATATION, CHRONIC — Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c) PARKINSON'S DISEASE — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (VA hospital) attended the deceased from Sept. 1, 1961, to Dec. 19, 1961, XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX and that death occured at 6:10PM from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney MD
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 12/20/61
22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D. Asst. Clinical Pathologist
22d. ADDRESS: VAH, Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/21/1961
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cem.
23d. LOCATION (City, town or county) (State): Ft. Myer, Va.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pennington & Son, Havre de Grace, Md.
25a. REC'D BY REGISTRAR — DATE: DEC 26 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and/in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13843 — 13818

1 (M)

Known locally as Bessie Garrison (Price)

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cecilton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA — Middle E. — Last PRICE

4. DATE OF DEATH: Month Dec. — Day 17, — Year 1961

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 14. 1883

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Cecilton Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Thompson

14. MOTHER'S MAIDEN NAME: Julia Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Emma Harrison — Address: 334 Print Alley Cecilton 3, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hours.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Myocardial infarction, massive — 6 hours.

DUE TO (c):

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Severe coronary sclerosis, severe congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 8 19 61 to 17 Dec 61 19....., that (I) (we) last saw the deceased alive on 17 Dec 61 19....., and that death occured at 4:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain M D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 19 Dec 61

22c. PHYSICIAN'S NAME (Type): Wallace Obenshain, M.D.

22d. ADDRESS: Cecilton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 21, 1961

23c. NAME OF CEMETERY OR CREMATORY: Cecilton Cemetery

23d. LOCATION (City, town or county) (State): Cecilton Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Edward Pullom — ADDRESS: Cecilton Md.

25a. REC'D BY REGISTRAR DATE: DEC 26 '61

25b. REGISTRAR'S SIGNATURE: Cecilton S. Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13844 — 13819

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
c. LENGTH OF STAY IN 1b: 42 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CURTIS — Middle: W. — Last: REED

4. DATE OF DEATH: Month: 12 — Day: 25 — Year: 19 61

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8-19-1874

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R.R. Bridge Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Penna R.R.

11. BIRTHPLACE (County & State, or foreign country): Penna

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: No imformation

14. MOTHER'S MAIDEN NAME: No information

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Albert Reed — Address: North East, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
DUE TO (b): 450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertrophic osteoarthritis, diabetes mellitus, prostatic hypertrophy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year — 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1 Jan ....., 1961, to 25 Dec ....., 1961, that (I) (we) last saw the deceased alive on 24 Dec ....1961..., and that death occured at 4 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Klaus H. Huebner M.D

22b. DATE SIGNED: 12/25/61

ATTEND NG PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Klaus H Huebner M.D

22d. ADDRESS: North East, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-28-1961

23c. NAME OF CEMETERY OR CREMATORY: Methodist

23d. LOCATION (City, town or county) (State): North East, Cecil Co., Md

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant

ADDRESS: Joseph R. Grant North East, Md

25a. REC'D BY REGISTRAR — DATE: DEC 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13845 13820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PERRY POINT
c. LENGTH OF STAY IN 1b: 1 yr. 22 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VETERANS ADMINISTRATION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 116 N. Pine Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle H. — Last RENNER

4. DATE OF DEATH: Month 12- — Day 19 — Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ (Separated)

8. DATE OF BIRTH: 2-20-93

9. AGE (In years last birthday): 68 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Houseman

10b. KIND OF BUSINESS OR INDUSTRY: Not available

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES RENNER

14. MOTHER'S MAIDEN NAME: GEORGIANA ANDERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW-1

16. SOCIAL SECURITY NO.: 213-16-5877

17. INFORMANT — Address: Hospital Records & Mother, Mrs. Georgian Renner, 3600 Fairview Ave., Balto., Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 7 Days
DUE TO
(b): Emphysema With Bronchiectasis — 1 Year
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I (did not) attended the deceased from 11-27- ..... 1960, to 12-19- ..... 1961, that I (saw) last saw the deceased on the 19th and that death occured at 2:56 PM from the causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney — M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-20-61

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY Asst. Clinical Pathologist

22d. ADDRESS: VA HOSPITAL, PERRY POINT, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL — 23b. DATE THEREOF: 12/22/1961

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son — ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: DEC 26 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Hanna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13846 — 13821

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1. **PLACE OF DEATH**
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: MARYLAND — 15 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Veterans Administration Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3806 Forrester Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle BRITTON — Last ROBBINS

4. DATE OF DEATH: Month December — Day 14 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-18-89

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Television

11. BIRTHPLACE (County & State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George B. Robbins (deceased)

14. MOTHER'S MAIDEN NAME: Elizabeth Thomas (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: 161-18-0680

17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia, Bilateral & RLL — INTERVAL BETWEEN ONSET AND DEATH: 2 To 3 Wks.

Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Lung Abscess,

DUE TO (c): Bronchogenic Carcinoma, Left Lung — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year: VA 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from November 29 1961 to December 14 1961 this (day) and that death occured 3:40 AM from the causes and on the date stated above

22a. SIGNATURE: A. L. Mooney M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12-14-61

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY Asst. Clinical

22d. ADDRESS: Pathologist, VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE THEREOF: 12/17/1961

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county): Arlington, Virginia (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Sons

ADDRESS: Havre de Grace Md

25a. REC'D BY REGISTRAR DATE: DEC 20 '61

25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13847

CERTIFICATE OF DEATH

Reg. Dist. No. 13822

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elk Mills
d. STREET ADDRESS: R d # 4,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Emiline — Last: Ruth

4. DATE OF DEATH: Month: 12 — Day: 25 — Year: 1961

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/22/1881

9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Temple

14. MOTHER'S MAIDEN NAME: Hoopes

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): * (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 213-14-4034

INFORMANT: Roy A. Temple — Address: Elk Mills Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: several yrs
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitis and fracture of left humerus on 12/16/61

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 14, 19 61 to Dec. 25, 19 61, that I last saw the deceased alive on Dec. 25, 19 61, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr. M.D.
ADDRESS (Street, city or town, state): 233 E. Main Street
DATE SIGNED: 12/26/61

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. — Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/28/61
22c. NAME OF CEMETERY OR CREMATORY: Lawn Croft Cemetery
22d. LOCATION (City, town, or county): Linwood (State): Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Walter [illegible] Jr.
ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: JAN 2 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13848

CERTIFICATE OF DEATH

13823

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7 61

1. **PLACE OF DEATH**
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2 Mn.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Shirley — Middle: R. — Last: Streets

4. **DATE OF DEATH**: Month: December — Day: 6 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 6, 1961

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min: 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Herman W. Streets

14. MOTHER'S MAIDEN NAME: Frances H. Clarke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wars or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Herman W. Streets — Address: Nr. Elkton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 750X — Anencephaly
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 7 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1961, to Dec 6, 1961, that (I) (we) last saw the deceased alive on Dec 6, 1961, and that death occured at 10 PM, from the causes and on the date stated above.

22a. SIGNATURE: Joseph G. Lanzi M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/8/61
22c. PHYSICIAN'S NAME (Type): Joseph G. Lanzi
22d. ADDRESS: 205 West Main Street Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Trl
23b. DATE THEREOF: 12/9/61
23c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery
23d. LOCATION (City, town or county) (State): Elkton, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] Donald M. Dr
ADDRESS: Elkton, Md.

25a. REC'D BY REGISTRAR DATE: DEC 14 61
25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13849

CERTIFICATE OF DEATH

13824

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CECIL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 34yrs3mos6days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
d. STREET ADDRESS: 121 Bonnie View Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: THOMAS Middle: JOSEPH Last: TRACY
4. DATE OF DEATH: Month: December Day: 2, Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-14-1894
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (County & State, or foreign country): Lewis County, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PATRICK J. TRACY
14. MOTHER'S MAIDEN NAME: MARY G. SCHMITT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): WW-1
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital Records, VA Hospital, Perry Point, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Diffuse Peritonitis w/Subdiaphragmatic Abscess.	3 to 6 days
DUE TO (b)	Acute perforation of duodenum	4 to 7 days
DUE TO (c)	Thrombosis of Pancreato-Duodenal artery	4 to 7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year: VA 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I ~~XXXXXXXXX~~ attended the deceased from August 25, 1927 to Dec. 2nd, 1961 ~~XXXXXXXXXXXXXXX~~ saw the deceased ~~XXXXXX~~ December 2, 1961, and that death occured at 4:50 PM, from the causes and on the date stated above.

22a. SIGNATURE: A.L. Mooney M.D
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: December 3, 1961
22c. PHYSICIAN'S NAME (Type): A.L.MOONEY, M.D.
22d. ADDRESS: Asst.Clinical Pathologist, VAH., Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/6/1961
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National
23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: [illegible] Havre DeGrace, Maryland
25a. REC'D BY REGISTRAR: DEC 20 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13850 Item 2 Film G302 1c/13/61 iwk 13825

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Route 1 Oakmont North East
d. STREET ADDRESS: 1 Comprehensive Nursing Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: ; Last: Troutner

4. DATE OF DEATH: Month: Dec; Day: 5; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 25 1878

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Commercial Fishing

11. BIRTHPLACE (County & State, or foreign country): no record

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: no record

14. MOTHER'S MAIDEN NAME: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 219-16-3985

17. INFORMANT: Welfare Records Cecil Co. Address: Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4 X Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 7 min.
DUE TO (b): Senility — years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebro-Vascular Accident - 4 days -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1 Dec, 19 61, to ....., 19....., that (I) (we) last saw the deceased alive on 5 Dec 1961, and that death occured at 5:55 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wallace Ohrenkamp M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6 Dec 61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Cecilton, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-7-1961

23c. NAME OF CEMETERY OR CREMATORY: Methodist

23d. LOCATION (City, town or county) (State): North East Cecil Co Md

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant ADDRESS: North East Md

25a. REC'D BY REGISTRAR DATE: DEC 8 '61

25b. REGISTRAR'S SIGNATURE: Clifton S Hancock

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 — 13851 — 14657

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKton
c. LENGTH OF STAY IN 1b: 1 HR
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: PA — b. COUNTY: Chester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Oxford
d. STREET ADDRESS: RD 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SANDRA Middle GEAN Last WEAVER

4. DATE OF DEATH: Month Dec Day 12 Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 12, 1961

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 1 Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Cecil County, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Weaver

14. MOTHER'S MAIDEN NAME: Joan Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT Address: Robert Weaver, RD 3, Oxford, Pa.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): (1) Congenital abscess, right diaphragm
DUE TO: with herniation of right lobe of liver
(b): into right thorax causing anoxia and atelectasis
DUE TO
(c): (2) Double intestinal malrotation

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 hr. / 1 hr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour — a.m. p.m. — Month, Day, Year — 19 —

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-12, 1961 to 12-12, 1961 that (I) (we) last saw the deceased alive on 12-12 19 61 and that death occured at 7:45 AM from the causes and on the date stated above.

22a. SIGNATURE: William D. Johnson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 12-14-61
22c. PHYSICIAN'S NAME (Type): William D. Johnson
22d. ADDRESS: 123 Singerly Ave Elkton

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec 14/61
23c. NAME OF CEMETERY OR CREMATORY: Oxford Cemetery
23d. LOCATION (City, town or county) (State): Oxford, Pennsylvania

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ralph E. Hicks, Elkton, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 11 '62
25b. REGISTRAR'S SIGNATURE: Catherine B. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7,61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13852

CERTIFICATE OF DEATH

13826

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 60 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution—Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): No 2 - Welsh Boulder Dr ELKTON
   d. STREET ADDRESS: Sugarloaf Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: John — Middle: C. — Last: Wisser

4. **DATE OF DEATH**: Month: DEC. — Day: 13 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 26 1908

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman Brick plant

10b. KIND OF BUSINESS OR INDUSTRY: Refractory Brick Works

11. BIRTHPLACE (County & State, or foreign country): Irrensburg Pa U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles E Wisser

14. MOTHER'S MAIDEN NAME: Elizabeth Meyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): UNK — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: CHARLES SMITH — Address: PITTSBURG, PA.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Heart Attack + Myocarditis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: One hour

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a): Diabetes about 3 years - Myocarditis - Heart Attack.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 11, 1961, to Dec 13, 1961, that (I) (we) last saw the deceased alive on Dec 13, 1961, and that death occured at 11:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: H. Arthur Cantwell M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Dec 14/61

22c. PHYSICIAN'S NAME (Type): H. Arthur Cantwell M.D.

22d. ADDRESS: North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/14/61

23c. NAME OF CEMETERY OR CREMATORY: Pittsburg

23d. LOCATION (City, town or county): Penna. (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Dippin Funeral Home — ADDRESS: Elkton

25a. REC'D BY REGISTRAR DATE: DEC 18 '61 — 25b. REGISTRAR'S SIGNATURE: Chas. S. Evans

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13853

13827

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): --

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Malin — Middle: A. — Last: Worth

4. DATE OF DEATH: Month: 12 — Day: 9 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9-14-1925

9. AGE (In years last birthday): 36 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager Laundry and Dry Cleaning Estab.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: I. Malin Worth

14. MOTHER'S MAIDEN NAME: Rachel E. Worth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes — WW II

16. SOCIAL SECURITY NO.: 216-16-8249

17. INFORMANT — Address: I. Malin Worth — Elkton, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiac Rupture	instant
DUE TO (b)	Coronary Infart	1 yr.
DUE TO (c)		

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12-10-1961

EXAMINER'S NAME (Type): R.C. Dodson

Address (Street, city, town, or county): Rising Sun, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **22b. DATE THEREOF**: 12-13-1961 — **22c. NAME OF CEMETERY OR CREMATORY**: Methodist — **22d. LOCATION** (City, town, or country) (State): North East, Cecil, Md.

23. FUNERAL DIRECTOR — ADDRESS: Joseph R. Grant — Joseph R. Grant North East, Md.

24a. REC'D BY REGISTRAR — DATE: DEC 14 '61

24b. REGISTRAR'S SIGNATURE: Carlton L. Frame

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13854 Item 6 Film G304 1/3/62 - iwk 13828

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: CECIL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
   c. LENGTH OF STAY IN 1b: 9 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: CECIL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 ELKTON
   d. STREET ADDRESS: 164 EAST MAIN
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First HARRY Middle S. Last WYRE

4. **DATE OF DEATH**: Month 12 Day 26 Year 1961

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-27-1943

9. AGE (In years last birthday): 18 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MILFORD WYRE

14. MOTHER'S MAIDEN NAME: Ada Rocky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: Mrs Ada W Wyre 164 E. Main St Elkton Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia, right — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO (b): Malnutrition — all of life

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 286.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Marked physical and mental retardation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ~~Dec. 17 61~~ 7:20a to ~~Dec. 26 61~~, 19....., that (I) (we) last saw the deceased alive on Dec. 25 1961, and that death occured at .....M, from the causes and on the date stated above.

22e. SIGNATURE: S. Ralph Andrews Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/26/61

22c. PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D.

22d. ADDRESS: 233 E. Main St., Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-29-61

23c. NAME OF CEMETERY OR CREMATORY: Methodist

23d. LOCATION (City, town or county) (State): North East Cecil Co Md

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant — ADDRESS: North East Md

25a. REC'D BY REGISTRAR DATE: DEC 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61